

# Stelara Injection Order (Ustekinumab)

**SMART CHOICE INFUSION**  
FOR YOUR HEALTH & WELLNESS

www.smartchoiceinfusion.com

Ph: 818-659-8182

Fax: 818-659-8990

Date: \_\_\_\_\_

Treatment Location: \_\_\_\_\_

**\*Please fax a copy of the  
following patient information:**

☐ Demographics

☐ Insurance Information

☐ Current CBC & CMP

☐ H & P Relevant to Diagnosis

☐ Current Medications List

☐ TB Results

☐ Colonoscopy & Pathology Report

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Allergies: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs / kg      Height: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

ICD-10: \_\_\_\_\_

## PROVIDER INFORMATION

Printed Provider's Name: \_\_\_\_\_

Signature: \_\_\_\_\_

NPI: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Office Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Contact Email: \_\_\_\_\_

## TB TEST

Result: \_\_\_\_\_ Test date: \_\_\_\_\_ ☐ Copy Attached

## STELARA INJECTION (USTEKINUMAB) DOSAGE

Date of Last Treatment, If Continuation: \_\_\_\_\_

### Stelara Injection 45 mg / 0.5 mL

#### Psoriatic Arthritis or Plaque Psoriasis

**Loading dose at weeks 0 and 4,  
then every 12 weeks, subcutaneous injection**

☐ 45 mg OR ☐ 90 mg

#### Crohn's Disease

**Maintenance Dose Only:**

☐ 90 mg subcutaneous injection  
8 weeks after initial IV dose  
then every 8 weeks.